

Prior Authorization Criteria

Effective 1-1-09

Name of drug/class	Approval Criteria
Age edits	The inclusion criterion for medically necessary medications with applicable member age edits is medical necessity documentation supplied by the prescriber
Alodox™	<p>Doxycycline hyclate (Alodox™) is approved when the following inclusion criteria is met:</p> <ul style="list-style-type: none"> • Documentation of contraindication to generic formulation of doxycycline hyclate
Altabax®	<p>Retapamulin (Altabax®) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documented diagnosis of impetigo in individuals 9 months of age or older • Documentation of a trial and failure of/contraindication/intolerance/allergy to mupirocin ointment
Alvesco™	<p>Ciclesonide (Alvesco™) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documentation of a diagnosis of asthma in patients 12 years of age and older • Documentation of trial and failure of or contraindication/intolerance/allergy to two of following: <ul style="list-style-type: none"> o Fluticasone-containing inhalation product o Budesonide-containing inhalation product o Triamcinolone acetonide (Azmacort) MDI
Amevive®	<p>The use of alefacept (Amevive®) is considered medically necessary and, therefore, covered for the treatment of adults with moderate-to-severe chronic plaque psoriasis who are candidates for systemic therapy or phototherapy, provided that all of the following inclusion criteria are met and exclusion criteria are not present:</p> <p>INCLUSION CRITERIA</p>

Name of drug/class	Approval Criteria
Amevive® (continued)	<ul style="list-style-type: none"> • Documentation of moderate-to-severe chronic plaque psoriasis • Failure, medical contraindication, or intolerance to two or more treatment modalities, including topical steroids, antipsoriatic agents, retinoids, and phototherapy • Prescribed and/or administered by a dermatologist or rheumatologist • Age of at least 18 years <p>EXCLUSION CRITERIA</p> <ul style="list-style-type: none"> • Documentation of mild chronic plaque psoriasis • History of systemic malignancy, presence of recurrent infection, allergy to alefacept (Amevive®) or their components • Concurrent use of other systemic immunosuppressive therapies or phototherapy • Prescribed and/or administered by a physician other than a dermatologist or rheumatologist • Age younger than 18 years
Amrix®	<p>Cyclobenzaprine hydrochloride extended-release (Amrix®) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documentation of trial and failure with at least 1 week therapy of cyclobenzaprine immediate release containing product • Documentation of trial and failure with at least 1 week therapy of one of the following drugs: <ul style="list-style-type: none"> ○ A baclofen containing product ○ A dantrolene containing product ○ A chlorzoxazone containing product ○ A methocarbamol containing product ○ Skelaxin ○ A carisoprodol containing product ○ A tizanidine containing product
Raptiva®	<p>Efalizumab (Raptiva®) is approved when the following inclusion criterion is met:</p> <ul style="list-style-type: none"> • Documented diagnosis of moderate to severe chronic plaque psoriasis and ALL of the following: <ul style="list-style-type: none"> ○ Patient is an adult (≥ 18 years) ○ Medication is being recommended and prescribed by a dermatologist ○ Patient had at least a 30-day trial and failure

Name of drug/class	Approval Criteria
Raptiva® (continued)	<p>with ONE of the following drugs OR contraindication to ALL of the following drugs:</p> <ul style="list-style-type: none"> ▪ Topical calcipotriene containing products ▪ Topical anthralin ▪ Topical steroids ▪ Topical immunomodulators (Elidel®, Protopic®) ▪ Topical retinoids ▪ Topical fluorouracil (Efudex®) ▪ Adalimumab (Humira®) ▪ Etanercept (Enbrel®) <ul style="list-style-type: none"> ○ Patient does not have concurrent immunosuppressive therapy ○ Patient does not have active infection ○ Patient does not have active malignancy
<p>Oral antihypertensives (Benicar®/Benicar HCT® Diovan®/Diovan HCT® Atacand®/Atacand HCT® Avapro®/Avalide® Azor™ Cozaar®/Hyzaar® Exforge® Micardis®/Micardis HCT® Teveten®/Teveten HCT® Tekturna®/Tekturna HCT®)</p>	<p><u>For new starts* only:</u></p> <p>VALSARTAN (DIOVAN/DIOVAN HCT), OLMESARTAN (BENICAR/BENICAR HCT)</p> <p>Valsartan (Diovan®/Diovan HCT®), olmesartan (Benicar®/Benicar HCT®) are approved when one of the following inclusion criterion is met:</p> <ul style="list-style-type: none"> • Documentation of a minimum 30-day trial and failure of or intolerance to at least one angiotensin converting enzyme (ACE) inhibitor-containing product (eg, enalapril maleate, lisinopril, moexipril HCl, fosinopril sodium, benazepril HCl, captopril, quinapril HCl) or ramipril (Altace) within the past six months • Diagnosis of Type 2 diabetes with renal insufficiency <p><u>For new starts* only:</u></p> <p>IRBESARTAN (AVAPRO®/AVALIDE®), CANDESARTAN (ATACAND®/ATACAND HCT®), LOSARTAN (COZAAR®/ HYZAAR®), TELMISARTAN (MICARDIS®/MICARDIS HCT®), EPROSARTAN (TEVETEN®/TEVETEN HCT®)</p> <p>Irbesartan (Avapro®/Avalide®), candesartan (Atacand®/Atacand HCT®), losartan (Cozaar®/ Hyzaar®), telmisartan (Micardis®/Micardis HCT®), eprosartan (Teveten®/Teveten HCT®) are approved when the following inclusion criterion is met:</p> <ul style="list-style-type: none"> • Documentation of a minimum 30-day trial and failure of or intolerance to valsartan (Diovan)- and olmesartan

Name of drug/class	Approval Criteria
Oral antihypertensives (continued)	<p>(Benicar)-containing products [Benicar®/Benicar HCT® and Diovan®/Diovan HCT® require prior authorization].</p> <p>In addition, one of the following inclusion criteria must also be met in order for treatment with irbesartan (Avapro, Avalide), candesartan (Atacand/Atacand HCT), losartan (Cozaar, Hyzaar), telmisartan (Micardis/Micardis HCT), eprosartan (Teveten/Teveten HCT) to be approved:</p> <ul style="list-style-type: none"> • Documentation of a minimum 30-day trial and failure of or intolerance to at least one ACE inhibitor-containing product (eg, enalapril maleate, lisinopril, moexipril HCl, fosinopril sodium, benazepril HCl, captopril, quinapril HCl) or ramipril (Altace) within the past six months • Diagnosis of Type 2 diabetes with renal insufficiency <p>ALISKIREN (TEKTURNA®)/ALISKIREN HCT (TEKTURNA HCT®)</p> <p>Aliskiren (Tekturna®) and aliskiren HCT (Tekturna HCT®) are approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documented diagnosis of hypertension • Documentation of trial and failure of or contraindication/intolerance/allergy to an ACE inhibitor • Documentation of trial and failure of or contraindication/intolerance/allergy to Diovan- or Benicar-containing products [Benicar®/Benicar HCT® and Diovan®/Diovan HCT® require prior authorization]. • Documentation of trial and failure of or contraindication/intolerance/allergy to an amlodipine-containing product <p>AMLODIPINE BESYLATE/OLMESARTAN (AZOR™)</p> <p>Amlodipine besylate/Olmesartan (Azor™) is approved when the following inclusion criterion is met:</p> <ul style="list-style-type: none"> • Documentation of a trial and failure of one of the following agents: <ul style="list-style-type: none"> ○ olmesartan/olmesartan HCT (Benicar®/Benicar HCT®) [Benicar®/Benicar HCT® requires prior authorization] ○ an amlodipine-containing product ○ an angiotensin converting enzyme (ACE) inhibitor-containing product

Name of drug/class	Approval Criteria
Oral antihypertensives (continued)	<p>AMLODIPINE BESYLATE/VALSARTAN (EXFORGE®)</p> <p>Amlodipine besylate/valsartan (Exforge®) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documentation of at least a 30-day trial of concurrent therapy of Valsartan/Valsartan HCT (Diovan®/Diovan HCT®) and an amlodipine-containing product [Benicar®/Benicar HCT® and Diovan®/Diovan HCT® require prior authorization]. • Documentation of non-compliance with valsartan/valsartan HCT (Diovan®/Diovan HCT®) and an amlodipine-containing product <p>*New start is defined as a member who has not received ARB therapy prior to the submission of the request.</p> <p>Criteria approved as of November 2008</p>
BiDil®	<p>Isosorbide dinitrate and hydralazine hydrochloride (BiDil®) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documentation of heart failure • Documentation of trial and failure or contraindication or intolerance to concurrent therapy with an isosorbide dinitrate product and a hydralazine product
Botox®/Myobloc®	<p>Botulinum toxin type A (BOTOX®) and botulinum toxin type B (MYOBLOC®) are considered medically necessary and, therefore, covered for the following indications:</p> <ul style="list-style-type: none"> • Severe primary focal hyperhidrosis that meets all of the following criteria: <ul style="list-style-type: none"> ○ The individual has focal, visible, severe sweating beyond physiological need that has been present for at least six months and is without apparent cause (eg, not due to an underlying disease, condition, or medication). ○ The condition has not responded to management with topical agents or iontophoresis. ○ At least two of the following characteristics are present: <ul style="list-style-type: none"> ▪ Age of onset is younger than 25 years of age.

Name of drug/class	Approval Criteria
Botox [®] /Myobloc [®] (continued)	<ul style="list-style-type: none"> ▪ Focal sweating is bilateral and relatively symmetric. ▪ Focal sweating does not occur during sleep. ▪ Family history is positive for severe primary focal hyperhidrosis. ▪ Hyperhidrosis significantly impairs participation in daily activities. <ul style="list-style-type: none"> • Dystonia • Blepharospasm • Strabismus in visually mature individuals (older than 10 years of age) who have vision in both eyes, are unable to maintain fusion of image, and have at least one of the following: <ul style="list-style-type: none"> ○ Diplopia ○ Abnormal head turn ○ Asthenopia ○ Impairment of peripheral vision due to esotropia • Organic writer's cramp • Spastic hemiplegia • Spastic paraplegia • Spasticity of the central nervous system with origin in one of the following: <ul style="list-style-type: none"> ○ Quadriplegia ○ Paraplegia ○ Diplegia ○ Monoplegia • Multiple sclerosis • Certain demyelinating diseases of the central nervous system • Infantile cerebral palsy • Hemifacial spasm • Disorders of binocular eye movements • Laryngeal spasms and diseases of the larynx not elsewhere classified • Achalasia and cardiospasm when at least one of the following criteria is met: <ul style="list-style-type: none"> ○ Conventional therapy has failed or is contraindicated. ○ The individual is at high risk of complications from pneumatic dilation or surgical myotomy. ○ Prior myotomy or pneumatic dilation has failed. ○ The individual has had prior dilation-induced esophageal perforation. ○ The individual has an epiphrenic diverticulum or hiatal hernia. • Anal spasm • Anal fissure • Unspecified torticollis

Name of drug/class	Approval Criteria
Botox [®] /Myobloc [®] (continued)	<ul style="list-style-type: none"> • Abductor spasmodic dysphonia • Disability from sialorrhea due to conditions such as motor neuron disease or Parkinson's disease in individuals who have failed or have a contraindication to traditional therapies (eg, anticholinergic agents, speech therapy, surgical therapy) • Urinary incontinence due to neurogenic bladder after documented failure of medical therapy (eg, pelvic floor exercises, diet/fluid management, anticholinergic agents, intermittent catheterization)
Byetta [®]	<p>Exenatide (Byetta[®]) is approved when the following inclusion criterion is met:</p> <ul style="list-style-type: none"> • Documentation of type 2 diabetes mellitus with concurrent use of one of the following: <ul style="list-style-type: none"> ○ Metformin ○ A sulfonylurea ○ A thiazolidinedione
Cesamet [®]	<p>Nabilone (Cesamet[®]) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documentation of chemotherapy-induced nausea and vomiting • Documentation of trial and failure of ondansetron containing product (Zofran[®]) and one of the following: granisetron HCL (Kytril[®]) or aprepitant (Emend[®])
Contraceptive agents (for members without contraceptive coverage)	Contraceptive agents are approved when the following inclusion criterion is met: documentation of noncontraceptive use.
COX-2 inhibitors (Celebrex [®] , Mobic [®]) (continued)	<p>Celecoxib (Celebrex[®]) is approved when one of the following inclusion criteria is met:</p> <ul style="list-style-type: none"> • Documentation of familial adenomatous polyposis (FAP) • Documentation of the failure of a meloxicam-containing product and one of the following: <ul style="list-style-type: none"> ○ Documentation of the trial and failure of two additional non-steroidal anti-inflammatory drugs (NSAIDs) ○ Documentation that the individual is 65 years of age or older ○ Documentation of concurrent warfarin use (within the last 90 days) ○ Documentation of a bleeding disorder ○ Documentation of concurrent systemic steroid

Name of drug/class	Approval Criteria
COX-2 inhibitors (Celebrex [®] , Mobic [®]) (continued)	<p style="text-align: center;">treatment</p> <ul style="list-style-type: none"> • Documentation of a history of gastrointestinal bleed, peptic ulcer, gastroesophageal reflux disease (GERD), or Barrett's esophagus. • Documentation of a concomitant condition in which celecoxib (Celebrex[®]) offers a significant advantage over non-COX-2 selective NSAIDs and meloxicam (Mobic[®]). <p>MELOXICAM (MOBIC[®])</p> <p>Brand meloxicam (Mobic[®]) is approved when the following inclusion criterion is met: Documentation of trial and failure or contraindication to generic meloxicam.</p>
Crestor [®]	<p>Rosuvastatin calcium (Crestor[®]) is approved when the following inclusion criteria is met:</p> <ul style="list-style-type: none"> • Documentation of a minimum 30-day trial and failure or contraindication/intolerance/allergy to one of the following agents: <ul style="list-style-type: none"> ○ Lovastatin-containing product ○ Pravastatin-containing product ○ Simvastatin-containing product
Cymbalta [®]	<p>MAJOR DEPRESSIVE DISORDER (MDD)</p> <p>Duloxetine (Cymbalta[®]) is approved when there is a documentation of a diagnosis of MDD and one of the following:</p> <ul style="list-style-type: none"> • Documentation of a trial and failure or intolerance to two of the following agents: <ul style="list-style-type: none"> ○ A bupropion-containing product ○ Citalopram ○ Escitalopram (Lexapro[®]) ○ Fluoxetine ○ Fluvoxamine ○ A paroxetine-containing product ○ Sertraline ○ A venlafaxine-containing product • Documentation of stabilization from an institutional setting • Documentation of current stabilization for over four weeks with corresponding dates <p>DIABETIC PERIPHERAL NEUROPATHY (DPN)</p> <p>Duloxetine (Cymbalta[®]) is approved when the following inclusion criterion is met: documentation of neuropathic pain associated with DPN secondary to diabetes with documented use of any diabetic medications.</p> <p>GENERALIZED ANXIETY DISORDER (GAD)</p>

Name of drug/class	Approval Criteria
Cymbalta® (continued)	<p>Duloxetine (Cymbalta®) is approved when there is a documentation of a diagnosis of GAD and one of the following:</p> <ul style="list-style-type: none"> • Documentation of a trial and failure or intolerance/contraindication/allergy to two of the following agents: <ul style="list-style-type: none"> ○ A bupropion-containing product ○ Citalopram ○ Escitalopram (Lexapro®) ○ Fluoxetine ○ Fluvoxamine ○ A paroxetine-containing product ○ Sertraline ○ A venlafaxine-containing product • Documentation of stabilization from an institutional setting • Documentation of current stabilization for over four weeks with corresponding dates <p>FIBROMYALGIA</p> <p>Duloxetine (Cymbalta®) is approved when the following inclusion criteria is met: documentation of a diagnosis of fibromyalgia.</p>
Daytrana®	<p>The methylphenidate transdermal patch (Daytrana®) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documented diagnosis of attention deficit hyperactivity disorder (ADHD) • Documented trial and failure of or contraindication/intolerance/allergy to two of the following agents: <ul style="list-style-type: none"> ○ A methylphenidate containing product ○ A mixed amphetamine salts containing product (eg, amphetamine-dextroamphetamine [Adderall® or Adderall XR®]) ○ Atomoxetine (Strattera®) ○ A dextroamphetamine-containing product ○ Methamphetamine hydrochloride (Desoxyn®) ○ A dexmethylphenidate containing product
Enbrel®	<p>Etanercept (Enbrel®) is approved when any of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documented diagnosis of moderate to severe Rheumatoid Arthritis, Ankylosing Spondylitis or Psoriatic Arthritis and all of the following: <ul style="list-style-type: none"> ○ Patient is an adult (≥ 18 years) ○ Medication is being recommended and prescribed by a rheumatologist

Name of drug/class	Approval Criteria
Enbrel® (continued)	<ul style="list-style-type: none"> o Patient had at least a 30 day trial and failure with ONE of the following disease-modifying anti-rheumatic drugs (DMARDs) OR contraindication to all of the following DMARDs: <ul style="list-style-type: none"> § Methotrexate § Hydroxychloroquine § Leflunomide § Azathioprine § Sulfasalazine § Adalimumab (Humira®) o Patient does not have concurrent therapy with Anakinra (Kineret®) or other tumor necrosis factor antagonists o Patient does not have active infections or sepsis o Patient has been evaluated (i.e. tuberculin skin test) and does not have active or latent tuberculosis o Patient does not have active malignancy • Documented diagnosis of Moderate to severe Juvenile Idiopathic Arthritis (JIA) and all of the following: <ul style="list-style-type: none"> o Patient is ≥ 2 years old to 17 years old o Medication is being recommended and prescribed by a rheumatologist o Patient had at least a 30 day trial and failure with ONE of the following disease-modifying anti-rheumatic drugs (DMARDs) OR contraindication to all of the following DMARDs: <ul style="list-style-type: none"> § Methotrexate § Hydroxychloroquine § Leflunomide § Azathioprine § Sulfasalazine § Adalimumab (Humira®) o Patient does not have concurrent therapy with Anakinra (Kineret®) or other tumor necrosis factor antagonists o Patient does not have active infections or sepsis o Patient has been evaluated (i.e. tuberculin skin test) and does not have active or latent tuberculosis o Patient does not have active malignancy • Documented diagnosis of moderate to severe Plaque Psoriasis and all of the following: <ul style="list-style-type: none"> o Patient is an adult (≥ 18 years) o Medication is being recommended and prescribed by a dermatologist o Patient had at least a 30 day trial and failure with ONE of the following drugs OR contraindication to all of the following drugs: <ul style="list-style-type: none"> § Topical Calcipotriene containing products § Topical Anthralin § Topical Steroids § Topical immunomodulators (Elidel®, Protopic®) § Topical retinoids

Name of drug/class	Approval Criteria
Enbrel® (continued)	<p style="text-align: center;">§ Efudex § Adalimumab (Humira®)</p> <ul style="list-style-type: none"> o Patient does not have concurrent therapy with anakinra (Kineret®) or other tumor necrosis factor antagonists o Patient does not have active infections or sepsis o Patient has been evaluated (i.e. tuberculin skin test) and does not have active or latent tuberculosis o Patient does not have active malignancy
Erectile Dysfunction drugs (Viagra®, Caverject®, Edex®, MUSE®, Levitra®, Cialis®)	<p>Erectile dysfunction agents are limited to a cumulative total of eight injections, tablets, or pellets per 30 days.</p> <p>Sildenafil (Viagra®), vardenafil (Levitra®), and tadalafil (Cialis®) are approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documentation of erectile dysfunction • No documentation or history of nitrate use within the past six months <p>In addition, for individuals who are younger than 55 years of age, one of the following inclusion criteria must be met in order for sildenafil (Viagra®), vardenafil (Levitra®), or tadalafil (Cialis®) to be approved:</p> <ul style="list-style-type: none"> • Documentation of a concomitant condition (such as diabetes, prostate cancer, pelvic surgery, radiation [eg, colon cancer], spinal cord injury, neurological disease) • Documentation of a normal testosterone level • Documentation of a low testosterone level and a low or normal prolactin level, with a trial and failure of/contraindication/intolerance/allergy to a testosterone-containing product • Documentation of a low testosterone level and a high prolactin level, with evidence of appropriate work up and treatment plan (treatment plan must be provided to the Company with this request) <p>Alprostadil (Muse®, Edex®, Caverject®) is approved when the following inclusion criterion is met:</p> <ul style="list-style-type: none"> • Documentation of erectile dysfunction <p>In addition, for individuals who are younger than 55 years of age, one of the following inclusion criteria must be met in order for alprostadil (Muse®, Edex®, Caverject®) to be approved:</p>

Name of drug/class	Approval Criteria
Erectile Dysfunction drugs (continued)	<ul style="list-style-type: none"> • Documentation of a concomitant condition (such as diabetes, prostate cancer, pelvic surgery, radiation [eg, colon cancer], spinal cord injury, neurological disease) • Documentation of a normal testosterone level • Documentation of a low testosterone level and a low or normal prolactin level, with a trial and failure of/contraindication/intolerance/allergy to a testosterone-containing product • Documentation of a low testosterone level and a high prolactin level, with evidence of appropriate work up and treatment plan (treatment plan must be provided to the Company with this request)
Exjade®	<p>Initial approval for the use of deferasirox (Exjade®) is valid for three months. Approval can be extended in three-month increments if a benefit is demonstrated.</p> <p>Deferasirox (Exjade®) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Individuals 2 years of age or older • Documentation of a diagnosis of chronic iron overload due to blood transfusions • Serum ferritin levels consistently greater than 1000 mcg/L (as demonstrated with at least two lab values within two months prior to treatment) <p>CONTINUATION CRITERION</p> <p>The continuation criterion for the use of deferasirox (Exjade®) is documentation of a decreased serum ferritin level compared with the baseline level.</p>
Experimental/Off label	<p>Consideration for coverage of off-label use must meet one of the following criteria:</p> <ul style="list-style-type: none"> • Documentation of accepted off-label use in one of the following compendia: <ul style="list-style-type: none"> ○ American Hospital Formulary Service (AHFS) Drug Information ○ US Pharmacopoeia Drug Information (USP DI Volume 1-now known as DrugPoints) ○ MicroMedex® DRUGDEX • The requested off-label use is supported by adequate submitted clinical research published in <u>major peer-reviewed medical journals</u>. For example:

Name of drug/class	Approval Criteria
Experimental/Off label (continued)	<ul style="list-style-type: none"> ○ The requested off-label use must have been studied in <u>at least two</u> clinical trials and must be, when possible, randomized, blinded, multi-centered and controlled. The results must have been published in national peer-reviewed journals with an editorial committee comprised of physicians. ○ Peer reviewed medical literature includes scientific, medical, and pharmaceutical publications. It does not include in-house publications of pharmaceutical manufacturing companies, abstracts (including meeting abstracts), poster presentations or published case studies.
Fentora [®]	<p>FENTANYL (FENTORA[®]) Fentanyl (Fentora[®]) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> ● Documentation of a diagnosis of breakthrough pain in individuals with cancer who are already receiving opioid therapy ● Documentation of tolerance to current opioid therapy (ie, adherence to one of the following regimens for one week or longer): <ul style="list-style-type: none"> ○ At least 25 mcg of transdermal fentanyl hourly ○ At least 30 mg of oxycodone daily ○ At least 60 mg of oral morphine daily ○ At least 8 mg of oral hydromorphone daily ○ An equianalgesic dose of another opioid ● Documentation of a trial and failure of oral transmucosal fentanyl citrate (Actiq[®]) for at least one week or longer
Flector [®]	<p>Diclofenac epolamine 1.3% (Flector[®] Patch) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> ● Documentation of pain. ● Documentation of the trial and failure or contraindication/intolerance to a meloxicam-containing product and one additional oral non-steroidal anti-inflammatory drug (NSAID).
Forteo [®]	<p>Teriparatide (Forteo[®]) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> ● Documented diagnosis of primary (postmenopausal) or hypogonadal osteoporosis

Name of drug/class	Approval Criteria
Forteo [®] (continued)	<ul style="list-style-type: none"> • Patients 18 years of age or older • Failure or intolerance with at least one of the following osteoporosis therapies <ul style="list-style-type: none"> ○ Bisphosphonates ○ Hormone replacement therapy ○ Selective-estrogen receptor modulators (SERM's) ○ Calcitonin-salmon (miacalcin) • No documentation of a contraindication to Forteo • ONE of the following: <ul style="list-style-type: none"> ○ Osteoporotic fractures or a history of osteoporotic fractures ○ Multiple risk factors for a fracture
Gender edits	The inclusion criterion for medications that have applicable gender edits is medical necessity documentation submitted by the physician.
Gleevec [®]	<p>Imatinib mesylate (Gleevec®) is approved when one of the following inclusion criteria is met:</p> <ul style="list-style-type: none"> • Documentation of a diagnosis of acute lymphoblastic leukemia (ALL) • Documentation of a diagnosis of aggressive systemic mastocytosis (ASM) • Documentation of a diagnosis of chronic myeloid leukemia (CML) • Documentation of a diagnosis of dermatofibrosarcoma protuberans (DFSP) • Documentation of a diagnosis of gastrointestinal stromal tumors (GIST) • Documentation of a diagnosis of hypereosinophilic syndrome (HES) and/or chronic eosinophilic leukemia (CEL) • Documentation of a diagnosis of myelodysplastic/myeloproliferative diseases (MDS/MPD) • Documentation of a diagnosis of neoplastic disease with documentation of the failure of conventional therapy
Glumetza [®]	<p>METFORMIN ER (GLUMETZA™)</p> <p>Metformin ER (Glumetza™) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documentation of type 2 diabetes mellitus • Documentation of the trial and failure of or

Name of drug/class	Approval Criteria
Glumetza® (continued)	intolerance/allergy/contraindication to either metformin IR- or metformin ER-containing products
Growth Hormone	Documentation of the following diagnoses: Growth Hormone (GH) deficiency in children, Chronic Renal insufficiency, Turner Syndrome, Prader-Willi Syndrome, SGA, GH deficiency in adults with adult/childhood-onset hypothalamic or pituitary disease, AIDS wasting, hypopituitarism in childhood, Neonates with suspected GH deficiency manifested by hypoglycemia, children with ISS, short bowel syndrome with documentation of required laboratory tests.
Humira®	<p>Adalimumab (Humira®) is approved when any of the following inclusion criteria is met:</p> <ul style="list-style-type: none"> · Documented diagnosis of moderate to severe Rheumatoid Arthritis, Ankylosing Spondylitis or Psoriatic Arthritis and ALL of the following: <ul style="list-style-type: none"> o Patient is an adult (≥ 18 years) o Medication is being recommended and prescribed by a rheumatologist o Patient had at least a 30 day trial and failure with ONE of the following disease-modifying anti-rheumatic drugs (DMARDs) OR contraindication to ALL of the following DMARDs: <ul style="list-style-type: none"> § Methotrexate § Hydroxychloroquine § Leflunomide § Azathioprine § Sulfasalazine § Etanercept (Enbrel®) o Patient is not on concurrent therapy with Anakinra (Kineret®) or other tumor necrosis factor antagonists o Patient does not have active infections or sepsis o Patient has been evaluated (i.e. tuberculin skin test) and does not have active or latent tuberculosis o Patient does not have active malignancy · Documented diagnosis of Moderate to severe Juvenile Idiopathic Arthritis (JIA) and ALL of the following: <ul style="list-style-type: none"> o Patient is ≥ 4 years old to 17 years old o Medication is being recommended and prescribed by a rheumatologist o Patient had at least a 30 day trial and failure with ONE of the following disease-modifying anti-rheumatic drugs (DMARDs) OR contraindication to ALL of the following DMARDs: <ul style="list-style-type: none"> § Methotrexate § Hydroxychloroquine § Leflunomide § Azathioprine

Name of drug/class	Approval Criteria
Humira® (continued)	<ul style="list-style-type: none"> § Sulfasalazine § Etanercept (Enbrel®) o Patient is not on concurrent therapy with Anakinra (Kineret®) or other tumor necrosis factor antagonists o Patient does not have active infections or sepsis o Patient has been evaluated (i.e. tuberculin skin test) and does not have active or latent tuberculosis o Patient does not have active malignancy <p>Documented diagnosis of moderate to severe Plaque Psoriasis and ALL of the following:</p> <ul style="list-style-type: none"> o Patient is an adult (≥ 18 years) o Medication is being recommended and prescribed by a dermatologist o Patient had at least a 30 day trial and failure with ONE of the following drugs OR contraindication to ALL of the following drugs: <ul style="list-style-type: none"> § Topical Calcipotriene containing products § Topical Anthralin § Topical Steroids § Topical immunomodulators (Elidel®, Protopic®) § Topical retinoids § Efadex § Etanercept (Enbrel®) o Patient is not on concurrent therapy with Anakinra (Kineret®) or other tumor necrosis factor antagonists o Patient does not have active infections or sepsis o Patient has been evaluated (i.e. tuberculin skin test) and does not have active or latent tuberculosis o Patient does not have active malignancy <p>Documented diagnosis of Crohn's Disease and ALL of the following:</p> <ul style="list-style-type: none"> o Patient is an adult (≥ 18 years old) o Medication is being recommended and prescribed by a gastroenterologist o Patient had at least a 30 day trial and failure with Infliximab (Remicade®) OR at least a 30 day trial and failure with one drug from any TWO of the following groups OR contraindication to ALL of the following groups: <ul style="list-style-type: none"> § Corticosteroids: Budesonide (Entocort® EC), Prednisone, Hydrocortisone, Methylprednisolone § Aminosalicylates: Sulfasalazine, Mesalamine (Asacol®, Rowasa®, Canasa®, Pentasa®), Olsalazine (Dipentum®), balsalazide (Colazal™) § Immunomodulators: Azathioprine, 6-mercaptopurine, Cyclosporine, Sirolimus (Prograf®), Methotrexate § Antibiotics: Metronidazole or Fluoroquinolones o Patient is not on concurrent therapy with Anakinra

Name of drug/class	Approval Criteria
Humira® (continued)	<p>(Kineret®) or tumor necrosis factor antagonists</p> <ul style="list-style-type: none"> o Patient does not have active infections or sepsis o Patient has been evaluated (i.e. tuberculin skin test) and does not have active or latent tuberculosis o Patient does not have active malignancy
Injectable Fertility quantity limit	<p>Injectable fertility medications are approved when both of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • The drug has been prescribed by a reproductive endocrinologist or gynecologist. • The member has a fertility benefit rider that allows for coverage of injectable fertility medications through the pharmacy benefit.
Invega®	<p>Paliperidone (Invega®) is approved when there is a documentation of a diagnosis of schizophrenia and one of the following:</p> <ul style="list-style-type: none"> • Documentation of a trial and failure of, or contraindication to, at least one of the following medications: <ul style="list-style-type: none"> o Aripiprazole (Abilify®) o Risperidone (Risperdal®) o Quetiapine fumarate (Seroquel®) o An olanzapine-containing product • Documentation of stabilization from an institutional setting • Documentation of current stabilization
Iressa®	<p>Gefitinib (Iressa®) is approved when the following inclusion criterion is met: The individual was documented as previously benefiting from gefitinib (Iressa®) therapy before September 15, 2005 and has registered through the Iressa Access Program to continue therapy.</p>
Januvia®	<p>Sitagliptin (Januvia®) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documentation of type 2 diabetes mellitus • Documentation of the trial and failure of or contraindication to a metformin-containing product • Documentation of the trial and failure of one of the following: <ul style="list-style-type: none"> o A thiazolidinedione o A sulfonylurea

Name of drug/class	Approval Criteria
Janumet™	<p>Sitagliptin/metformin (Janumet™) is approved when there is documentation of type 2 diabetes mellitus and when one of the following inclusion criteria is met:</p> <ul style="list-style-type: none"> • Documentation of current concomitant therapy with sitagliptin and metformin • Documentation of current therapy with metformin and the trial and failure of one of the following: <ul style="list-style-type: none"> ○ A thiazolidinedione ○ A sulfonylurea • Documentation of current therapy with metformin and a contraindication to both of the following: <ul style="list-style-type: none"> ○ A thiazolidinedione ○ A sulfonylurea
Kineret®	<p>Anakinra (Kineret®) is approved when the following inclusion criterion is met:</p> <ul style="list-style-type: none"> • Documentation of a diagnosis of moderate to severe rheumatoid arthritis and ALL of the following: <ul style="list-style-type: none"> ○ Patient is an adult (≥ 18 years) ○ Medication is being recommended and prescribed by a rheumatologist ○ Patient had at least a 30 day trial and failure with ONE of the following disease-modifying anti-rheumatic drugs (DMARDs) OR contraindication to ALL of the following DMARDs: <ul style="list-style-type: none"> ▪ Methotrexate ▪ Hydroxychloroquine ▪ Leflunomide ▪ Azathioprine ▪ Sulfasalazine ▪ Adalimumab (Humira®) ▪ Etanercept (Enbrel®) ○ Patient is not on concurrent therapy with tumor necrosis factor antagonists ○ Patient does not have active infections or sepsis ○ Patient has been evaluated (i.e. tuberculin skin test) and does not have active or latent tuberculosis ○ Patient does not have active malignancy
Lipitor® and Caduet®	<p>Atorvastatin (Lipitor®) or amlodipine/atorvastatin (Caduet®) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documentation of a minimum 30-day trial and failure or contraindication/intolerance/allergy to one of the

Name of drug/class	Approval Criteria
Lipitor [®] and Caduet [®] (continued)	<p>following agents:</p> <ul style="list-style-type: none"> ○ Lovastatin-containing product ○ Pravastatin-containing product ○ Simvastatin-containing product <ul style="list-style-type: none"> • Documentation of a minimum 30-day trial and failure or contraindication/intolerance/allergy to rosuvastatin calcium (Crestor[®])
Lyrica [®]	<p>Pregabalin (Lyrica[®]) is approved when one of the following inclusion criteria is met:</p> <ul style="list-style-type: none"> • Documentation of neuropathic pain that is associated with diabetic peripheral neuropathy (DPN) secondary to diabetes • Documentation of add-on therapy for partial onset epileptic seizures in adults with trial and failure or contraindication/intolerance/allergy to gabapentin • Documentation of diagnosis of postherpetic neuralgia with trial and failure or contraindication/intolerance/allergy to gabapentin • Documentation of diagnosis of fibromyalgia • Documentation of diagnosis of non-diabetic neuropathic pain with trial and failure or contraindication/intolerance/allergy to gabapentin and any three of the following medications: <ul style="list-style-type: none"> ○ An opioid containing product ○ Tramadol ○ A tricyclic antidepressant ○ A lidocaine-containing product ○ Carbamazepine ○ A venlafaxine-containing product
Magnacet [®]	<p>Oxycodone/acetaminophen (Magnacet[®]) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documentation of the trial and failure/intolerance to an oxycodone/acetaminophen-containing product with 325 mg of acetaminophen • Documentation of the reason why an oxycodone/acetaminophen-containing product with greater than 400 mg of acetaminophen would not be appropriate
Migraine agent quantity edit (Amerge [®] , Axert [®] , Frova [®] , Imitrex [®] , Maxalt [®] , Migranal [®] , Relpax [®] , Stadol [®] , Zomig [®])	Migraine agents are approved when all of the following inclusion criteria are met:

Name of drug/class	Approval Criteria
Migraine agent quantity edit (Amerge [®] , Axert [®] , Frova [®] , Imitrex [®] , Maxalt [®] , Migranal [®] , Relpax [®] , Stadol [®] , Zomig [®]) (Continued)	<ul style="list-style-type: none"> • There is a documented diagnosis of migraine headaches. • There has been a trial of prophylactic treatment with beta blockers, calcium channel blockers, tricyclic antidepressants, valproic acid, methylsergide, cyproheptadine, etc. • The requested quantity does not exceed the manufacturer-recommended maximum daily doses. • The individual has been examined by a neurologist within the past three years
Nexavar [®]	Sorafenib (Nexavar[®]) is approved when the following inclusion criterion is met: The individual has a diagnosis of advanced renal cell carcinoma or a diagnosis of unresectable hepatocellular carcinoma.
Non-Formulary requests	Inclusion criteria for the use of nonformulary medications at the formulary benefit level include one of the following: <ul style="list-style-type: none"> • An allergy or contraindication to all current or approved formulary alternative(s) • A trial and failure or inappropriate clinical response to all current or approved formulary alternative(s)
Noxafil [®]	Posaconazole (NOXAFIL[®]) is approved for an individual who is 13 years of age or more when any one of the following inclusion criteria is met: <ul style="list-style-type: none"> • Use in prophylaxis of invasive Aspergillus and Candida infections due to a severe immunocompromised state • Use in the treatment of invasive Aspergillus and Candida infections due to a severe immunocompromised state after trial and failure of voriconazole (Vfend[®]) • Diagnosis of oropharyngeal candidiasis with failed trials of itraconazole and fluconazole
Omnaris [™]	Ciclesonide (Omnaris[™]) is approved when there is documentation that the individual is 6 years of age or older with a diagnosis of seasonal or perennial allergic rhinitis and all of the following inclusion criteria are met: <ul style="list-style-type: none"> • Documentation of a trial and failure of or intolerance/contraindication/allergy to a fluticasone propionate containing nasal product • Documentation of a trial and failure of or

Name of drug/class	Approval Criteria
Omnaris™ (continued)	<p>intolerance/contraindication/allergy to one of the following:</p> <ul style="list-style-type: none"> ○ Mometasone furoate monohydrate (Nasonex®) ○ Triamcinolone acetonide (Nasacort® AQ)
Opana®	<p>Oxymorphone (Opana®) is approved when one of the following inclusion criteria is met:</p> <ul style="list-style-type: none"> • Documentation of the trial and failure of or contraindication/allergy/intolerance to all of the following: <ul style="list-style-type: none"> ○ Oxycodone IR-containing product ○ Codeine phosphate ○ Hydromorphone ○ Morphine sulfate IR • Authorization for oxymorphone extended-release (ER) (Opana ER®)
Opana ER®	<p>Oxymorphone ER (Opana ER®) is approved when one of the following inclusion criteria is met:</p> <ul style="list-style-type: none"> • Documentation of the trial and failure of or contraindication/allergy/intolerance to both of the following: <ul style="list-style-type: none"> ○ Oxycodone ER ○ Morphine sulfate sustained-release (SR) • Authorization for oxymorphone IR (Opana®)
Oracea®	<p>Doxycycline (Oracea®) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documentation of diagnosis of Rosacea • Documentation of trial and failure or contraindication/intolerance/allergy to topical metronidazole and one other formulation of oral doxycycline
Oral transmucosal fentanyl citrate (Actiq®)	<p>(For initial and subsequent requests)</p> <p>Oral transmucosal fentanyl citrate (Actiq®) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documentation of a diagnosis of breakthrough pain due to/associated with cancer

Name of drug/class	Approval Criteria
Oral transmucosal fentanyl citrate (Actiq®) (continued)	<ul style="list-style-type: none"> • Documentation of age 16 and older • Documentation of tolerance to current opioid therapy (ie, adherence to one of the following regimens for one week or longer): <ul style="list-style-type: none"> ○ At least 25 mcg of transdermal fentanyl hourly ○ At least 30 mg of oxycodone daily ○ At least 60 mg of oral morphine daily ○ At least 8 mg of oral hydromorphone daily ○ An equianalgesic dose of another opioid • Documentation of a trial and failure of generic oral transmucosal fentanyl citrate (generic oral transmucosal fentanyl citrate requires prior authorization) for at least one week or longer
Oral transmucosal fentanyl citrate (generic)	<p>(For initial and subsequent requests) Generic oral transmucosal fentanyl citrate is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documentation of a diagnosis of breakthrough pain due to/associated with cancer • Documentation of age 16 and older • Documentation of tolerance to current opioid therapy (ie, adherence to one of the following regimens for one week or longer): <ul style="list-style-type: none"> ○ At least 25 mcg of transdermal fentanyl hourly ○ At least 30 mg of oxycodone daily ○ At least 60 mg of oral morphine daily ○ At least 8 mg of oral hydromorphone daily ○ An equianalgesic dose of another opioid
Pataday™	<p>Olopatadine hydrochloride (Pataday™) 0.2 percent is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documentation of allergic conjunctivitis • Documentation of trial and failure or contraindication to all of the following agents: <ul style="list-style-type: none"> ○ Olopatadine hydrochloride ophthalmic solution (Patanol®) ○ Azelastine hydrochloride ophthalmic solution (Optivar®)
Pristiq™	<p>Desvenlafaxine (Pristiq™) is approved when there is a documentation of a diagnosis of major depressive disorder (MDD) and one of the following:</p> <ul style="list-style-type: none"> • Documentation of a trial and failure/intolerance to two of the following agents: <ul style="list-style-type: none"> ○ A bupropion-containing product

Name of drug/class	Approval Criteria
Pristiq™ (continued)	<ul style="list-style-type: none"> ○ Citalopram ○ Escitalopram (Lexapro®) ○ Fluoxetine ○ Fluvoxamine ○ A paroxetine-containing product ○ Sertraline ○ A venlafaxine-containing product ● Documentation of stabilization from an institutional setting ● Documentation of current stabilization for over four weeks with corresponding dates
Proton Pump Inhibitors (Aciphex®, Prevacid®/Prevacid NapraPAC®, Nexium®, Protonix®, Zegerid, Pylera®.)	<p>ESOMEPRAZOLE (NEXIUM®) AND LANSOPRAZOLE (PREVACID®)</p> <p>Esomeprazole (Nexium®) or lansoprazole (Prevacid®) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> ● Documentation of any of the indications specified for the drug (See Policy List of Applicable Drugs) ● A documented trial and failure or contraindication/intolerance/allergy to a prescription generic omeprazole or pantoprazole lasting at least 14 days <p>ESOMEPRAZOLE (NEXIUM®) FOR DELAYED-RELEASE ORAL SUSPENSION, LANSOPRAZOLE (PREVACID®) ORALLY DISINTEGRATING TABLETS, AND LANSOPRAZOLE (PREVACID®) GRANULES FOR ORAL SUSPENSION</p> <p>Esomeprazole (Nexium®) for delayed-release oral suspension, lansoprazole (Prevacid®) orally disintegrating tablets, or lansoprazole (Prevacid®) granules for oral suspension are approved when one of the following inclusion criteria is met:</p> <ul style="list-style-type: none"> ● The individual is under 12 years of age with documentation of any of the indications specified for the drug. (See Policy List of Applicable Drugs) ● Documentation of the inability to swallow capsules/tablets (eg, dysphagia, gastrointestinal [GI] tubes) along with documentation of any of the indications specified for the drug <p>LANSOPRAZOLE/NAPROXEN (PREVACID NAPRAPAC®)</p> <p>Lansoprazole/naproxen (Prevacid NapraPAC®) is approved when the following inclusion criterion is met: Documentation of any of the indications specified for lansoprazole/naproxen (Prevacid NapraPAC®). (See Policy List of Applicable Drugs)</p> <p>RABEPRAZOLE (ACIPHEX®), PANTOPRAZOLE (PROTONIX®), AND OMEPRAZOLE/SODIUM BICARBONATE (ZEGERID®)</p>

Name of drug/class	Approval Criteria
Proton Pump Inhibitors (continued)	<p>Rabeprazole (Aciphex®), pantoprazole (Protonix®), or omeprazole/sodium bicarbonate (Zegerid®) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • A documented trial of products containing esomeprazole (Nexium®) and lansoprazole (Prevacid®) • Documentation of any of the indications specified for the drug (See Policy List of Applicable Drugs) • A documented trial and failure or contraindication/intolerance/allergy to prescription generic omeprazole or pantoprazole lasting at least 14 days <p>BISMUTH SUBCITRATE POTASSIUM, METRONIDAZOLE, AND TETRACYCLINE HYDROCHLORIDE (PYLERA®)</p> <p>Bismuth subcitrate potassium, metronidazole, and tetracycline hydrochloride (Pylera®) is approved when the following inclusion criterion is met: Documented diagnosis of <i>Helicobacter pylori</i>.</p>
Provigil®	<p>Modafinil (Provigil®) is approved when one of the following inclusion criteria is met:</p> <ul style="list-style-type: none"> • Diagnosis of narcolepsy, idiopathic hypersomnia, or obstructive sleep apnea/hypopnea syndrome with recommendation of modafinil (Provigil®) by a neurologist or sleep specialist and a report of a sleep study supporting such diagnosis • Diagnosis of shift work sleep disorder with recommendation of modafinil (Provigil®) by a neurologist or sleep specialist and clinical evaluation demonstrating both of the following: <ul style="list-style-type: none"> ○ A shift work schedule that is likely to result in sleepiness ○ Patient counseling for reducing the negative effects of shift work (eg, napping, bright light avoidance, request for change in shift) that has failed • Diagnosis of fatigue associated with multiple sclerosis with recommendation of modafinil (Provigil®) by a neurologist

Name of drug/class	Approval Criteria
Quaalquin™	<p>Quinine sulfate (Quaalquin™) is approved when the following inclusion criterion is met:</p> <ul style="list-style-type: none">• Documentation of uncomplicated Plasmodium falciparum malaria
Quantity level limits	Inclusion criteria include appropriate documentation of medical necessity supplied by the prescriber.

Name of drug/class	Approval Criteria
Ranexa®	<p>Ranolazine (Ranexa®) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documentation of insufficient response, intolerance, or contraindication to at least one medication from each of the following: <ul style="list-style-type: none"> ○ Long-acting nitrates: Isosorbide dinitrate, Isosorbide mononitrate, Nitroglycerin patches ○ Beta-blockers: Atenolol, Acebutolol, Carvedilol, Penbutolol, Labetalol, Pindolol, Metoprolol, Nadolol, Betaxolol, Bisoprolol, Timolol, or Propranolol ○ Calcium channel blockers: Nifedipine, Felodipine, Amlodipine, Diltiazem, or Verapamil • Documentation of concurrent treatment with one of the following: <ul style="list-style-type: none"> ○ Amlodipine ○ Beta-blockers: Atenolol, Acebutolol, Carvedilol, Penbutolol, Labetalol, Pindolol, Metoprolol, Nadolol, Betaxolol, Bisoprolol, Timolol, or Propranolol ○ Long-acting nitrates: Isosorbide dinitrate, Isosorbide mononitrate, Nitroglycerin patches

Name of drug/class	Approval Criteria
Raptiva®	<p>Efalizumab (Raptiva®) is approved when the following inclusion criterion is met:</p> <ul style="list-style-type: none"> • Documented diagnosis of moderate to severe chronic plaque psoriasis and ALL of the following: <ul style="list-style-type: none"> ○ Patient is an adult (≥ 18 years) ○ Medication is being recommended and prescribed by a dermatologist ○ Patient had at least a 30-day trial and failure with ONE of the following drugs OR contraindication to ALL of the following drugs: <ul style="list-style-type: none"> ▪ Topical calcipotriene containing products ▪ Topical anthralin ▪ Topical steroids ▪ Topical immunomodulators (Elidel®, Protopic®) ▪ Topical retinoids ▪ Topical fluorouracil (Efudex®) ▪ Adalimumab (Humira®) ▪ Etanercept (Enbrel®) ○ Patient does not have concurrent immunosuppressive therapy ○ Patient does not have active infection ○ Patient does not have active malignancy

Name of drug/class	Approval Criteria
Requip® XL™	<p>Ropinirole extended-release tablets (Requip® XL™) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documentation of a diagnosis of Parkinson's disease • Documentation of non-compliance with a 30 day therapy of Ropinirole immediate release containing product
Revatio®	<p>Sildenafil (Revatio®) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documentation of a diagnosis of pulmonary arterial hypertension • No history of a nitrate prescription being filled within the last six months
Revlimid®	<p>Lenalidomide (Revlimid®) is approved for individuals who are registered with the RevAssist(SM) Program when one of the following inclusion criteria is met:</p> <ul style="list-style-type: none"> • A diagnosis of transfusion-dependent anemia, due to low- or intermediate-1-risk myelodysplastic syndromes that are associated with a deletion 5q cytogenetic abnormality, with or without additional cytogenetic abnormalities • A diagnosis of multiple myeloma in combination with dexamethasone for individuals who received at least one prior therapy (eg, stem cell transplantation, thalidomide, dexamethasone, mephalan, doxorubicin, vincristine, cyclophosphamide, carmustine, velcade)

Name of drug/class	Approval Criteria
Schedule II Oral Tablet/Capsule/Lozenge Quantity Level Limit	<p>An increased quantity of a schedule II oral agent is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documentation of appropriate diagnosis upon visit with a qualified specialist • Evidence to support the medical necessity of the requested dose
Seroquel XR [®]	<p>Quetiapine fumarate (Seroquel XR[®]) is approved when there is a documentation of a diagnosis of schizophrenia or bipolar disorder and one of the following:</p> <ul style="list-style-type: none"> • Documentation of a trial and failure of, or contraindication to, at least one of the following medications: <ul style="list-style-type: none"> ○ Aripiprazole (Abilify[®]) ○ Risperidone (Risperdal[®]) ○ Quetiapine fumarate immediate-release (Seroquel[®]) ○ An olanzapine-containing product • Documentation of stabilization from an institutional setting • Documentation of current stabilization
Singulair [®]	<p>Montelukast (Singulair[®]) is approved when one of the following inclusion criteria is met:</p> <ul style="list-style-type: none"> • Documentation of a diagnosis of asthma in individuals 12 months of age and older • Documentation for prevention of exercise-induced bronchoconstriction in individuals 15 years of age and older • Documentation of a diagnosis of allergic rhinitis in individuals 6 months of age and older with documented failure of at least one of the following: <ul style="list-style-type: none"> ○ Prescription nonsedating antihistamine (eg, fexofenadine [Allegra[®]], desloratadine [Clarinex[®]], levocetirizine [Xyzal[®]]) ○ Over-the-counter nonsedating antihistamine (eg, loratadine [Claritin[®], Alavert[®]], cetirizine [Zyrtec[®]]) ○ Intranasal corticosteroid (eg, beclomethasone [Vancenase[®]], budesonide [Rhinocort[®]], fluticasone [Flonase[®]], mometasone [Nasonex[®]], triamcinolone [Nasacort[®]])
Sleep agents (Ambien CR [®] , Lunesta [®])	<p>Eszopiclone (Lunesta[®]) and zolpidem tartrate extended-release (Ambien CR[®]) are approved when all of the following</p>

Name of drug/class	Approval Criteria
Sleep agents (Ambien CR [®] , Lunesta [®]) (Continued)	inclusion criteria are met: <ul style="list-style-type: none"> • Diagnosis of insomnia • Documentation of a trial and failure of a zolpidem tartrate immediate-release-containing product for a minimum of 14 days
Sleep agents (Rozerem [®])	<p>Ramelteon (Rozerem[®]) is approved when the following inclusion criterion is met:</p> <ul style="list-style-type: none"> • Diagnosis of insomnia <p>In addition, one of the following criteria must also be met in order for ramelteon (Rozerem[®]) to be approved:</p> <ul style="list-style-type: none"> • Documentation of a trial and failure of a zolpidem tartrate immediate-release-containing product for a minimum of 14 days • Documentation of abuse potential
Simcor [®]	<p>Niacin extended-release/simvastatin (Simcor[®]) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documentation of a minimum 30 day trial of concurrent use of a prescription niacin product and a simvastatin-containing product • Documentation of non-compliance with the concurrent use of a prescription niacin product and a simvastatin-containing product
Sprycel [®]	<p>Dasatinib (Sprycel[®]) is approved when one of the following inclusion criteria is met:</p> <ul style="list-style-type: none"> • Documentation of CML in any phase (chronic, accelerated, myeloid, or lymphoid blast phase) with resistance or intolerance to prior therapy, including imatinib mesylate (Gleevec[®]) • Documentation of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL) with resistance or intolerance to prior therapy, including imatinib mesylate (Gleevec[®])
Sutent [®]	Sunitinib malate (Sutent[®]) is approved when one of the

Name of drug/class	Approval Criteria
Sutent® (continued)	<p>following inclusion criteria is met:</p> <ul style="list-style-type: none"> • Documentation of a diagnosis of gastrointestinal stromal tumors (GIST) after disease progression on imatinib mesylate (Gleevec®) or documented intolerance to imatinib mesylate (Gleevec®) • A diagnosis of advanced renal cell carcinoma (RCC)
Symbicort®	<p>Budesonide/formoterol fumarate dihydrate (Symbicort®) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documentation of a diagnosis of asthma in patients 12 years of age and older • Documentation of trial and failure of or contraindication/intolerance/allergy to concurrent use of a long-acting beta2-agonist and an inhaled corticosteroid
Symlin®	<p>Pramlintide (Symlin®/SymlinPen®) is approved when one of the following inclusion criteria is met:</p> <ul style="list-style-type: none"> • Documentation of type 1 diabetes with concurrent insulin therapy • Documentation of type 2 diabetes with concurrent insulin therapy and trial and failure of one of the following medications: <ul style="list-style-type: none"> ○ Metformin-containing product ○ Sulfonylurea-containing product ○ Thiazolidinedione-containing product • Documentation of type 2 diabetes with concurrent insulin therapy and a contraindication to all of the following medications: <ul style="list-style-type: none"> ○ Metformin-containing product ○ Sulfonylurea-containing product ○ Thiazolidinedione-containing product
Taclonex®/Taclonex Scalp®	<p>Calcipotriene and betamethasone dipropionate (Taclonex®/Taclonex Scalp®) is approved when both of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documentation of psoriasis vulgaris in adults 18 years of age or older • Documentation of the trial and failure of/intolerance to concurrent use of calcipotriene (Dovonex®) and a topical betamethasone product
Thalomid®	<p>Thalidomide (Thalomid®) is approved when one of the</p>

Name of drug/class	Approval Criteria
Thalomid® (Continued)	<p>following inclusion criteria is met:</p> <ul style="list-style-type: none"> • Documentation of acute treatment of cutaneous manifestations of moderate-to-severe erythema nodosum leprosum (ENL) • Documentation of maintenance therapy for prevention and suppression of erythema nodosum leprosum (ENL) occurrence • Documentation of first-line therapy for multiple myeloma • Documentation of a diagnosis of neoplastic disease with documented failure of conventional therapy
Tarceva®	<p>Erlotinib (Tarceva®) is approved when one of the following inclusion criteria is met:</p> <ul style="list-style-type: none"> • Documentation of a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) and documentation of at least one prior chemotherapy regimen that failed or is contraindicated • Documentation of a diagnosis of locally advanced, unresectable, or metastatic pancreatic cancer in combination with gemcitabine (Gemzar®) as a first-line therapy.
Tasigna®	<p>Nilotinib (Tasigna®) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documentation of a diagnosis of chronic-phase or accelerated-phase Philadelphia chromosome-positive chronic myelogenous leukemia (CML) • Documentation of resistance to or intolerance to imatinib mesylate (Gleevec®)
Topical Retinoids	<p>The use of topical retinoid products is approved when the following inclusion criterion is met:</p> <ul style="list-style-type: none"> • A diagnosis consistent with a noncosmetic use of the drug, including acne vulgaris
Treximet™	<p>Sumatriptan and naproxen sodium (Treximet™) is approved when all of the following exclusion criteria are present:</p>

Name of drug/class	Approval Criteria
Treximet™ (continued)	<ul style="list-style-type: none"> • Documentation of a diagnosis of migraine • Documentation of a trial and failure of concurrent therapy with Imitrex and Naproxen containing product
Tykerb®	<p>Lapatinib (Tykerb®) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documentation of advanced or metastatic breast cancer • Documentation of a tumor with overexpression of HER2 • Documentation of concurrent treatment with capecitabine • Documentation of prior therapy with all of the following: <ul style="list-style-type: none"> ○ An anthracycline ○ A taxane ○ Trastuzumab (Herceptin®)
Ultram ER®	<p>Tramadol extended-release (ER) (Ultram ER®) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • The individual is 18 years of age or more • The individual failed or was intolerant to a trial of at least one preferred analgesic medication indicated for moderate to moderately severe pain, such as the following: <ul style="list-style-type: none"> ○ Propoxyphene/acetaminophen (APAP) ○ Non-steroidal anti-inflammatory agents/analgesics [NSAIDs] [diflunisal, naproxen sodium, flurbiprofen, etodolac, meclufenamate ibuprofen, fenoprofen calcium, ketoprofen, nabumetone, diclofenac sodium] ○ Opioid analgesics [oxycodone/APAP, morphine sulfate, codeine phosphate, codeine sulfate, meperidine, hydromorphone, methadone, fentanyl, hydrocodone/APAP, oxycodone, oxycodone/aspirin (ASA), codeine/APAP, hydrocodone/ibuprofen] • Documentation of a trial and failure of or intolerance to tramadol (Ultram®)
Veramyst®	<p>Fluticasone furoate (Veramyst®) is approved when there is documentation of a diagnosis of seasonal or perennial allergic rhinitis and one of the following:</p>

Name of drug/class	Approval Criteria
Veramyst® (continued)	<ul style="list-style-type: none"> • Documentation that the individual is 2 or 3 years of age, with documentation of trial and failure of or intolerance/contraindication/allergy to mometasone furoate monohydrate (Nasonex®) and triamcinolone acetonide (Nasacort AQ) • Documentation that the individual is 4 years of age or older, with documentation of trial and failure of or intolerance/contraindication/allergy to fluticasone propionate containing nasal product and one of the following: <ul style="list-style-type: none"> ○ Mometasone furoate monohydrate (Nasonex®) ○ Triamcinolone acetonide (Nasacort® AQ)
Voltaren® Gel	<p>Diclofenac sodium 1% (Voltaren® Gel) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documentation of pain. • Documentation of the trial and failure or contraindication/intolerance to a meloxicam-containing product and one additional oral non-steroidal anti-inflammatory drug (NSAID).
Vytorin®	<p>Ezetimibe/simvastatin (Vytorin®) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documentation of a minimum 30-day trial and failure or contraindication/intolerance/allergy to one of the following agents: <ul style="list-style-type: none"> ○ Lovastatin-containing product ○ Pravastatin-containing product ○ Simvastatin-containing product • Documentation of a minimum 30-day trial and failure or contraindication/intolerance/allergy to rosuvastatin calcium (Crestor®)
Vyvanse®	<p>Lisdexamfetamine dimesylate (Vyvanse®) is approved when there is documentation of a diagnosis of attention-deficit hyperactivity disorder (ADHD) and when one of the following inclusion criteria is met:</p> <ul style="list-style-type: none"> • Documentation of a trial and failure or contraindication/intolerance/allergy to any two of the following medications:

Name of drug/class	Approval Criteria
Vyvanse® (continued)	<ul style="list-style-type: none"> ○ A methylphenidate containing product ○ A mixed amphetamine salts containing product (eg, amphetamine-dextroamphetamine [Adderall or Adderall XR]) ○ Atomoxetine hydrochloride (Strattera®) ○ A dextroamphetamine containing product ○ Methamphetamine hydrochloride (Desoxyn®) ○ A dexmethylphenidate containing product ● Documentation of a history of or a potential for drug abuse among the individual or a member of the individual's household
Weight loss agents (when permitted for morbid obesity)	<p>Weight loss agents are approved when the following inclusion criterion is met:</p> <ul style="list-style-type: none"> ● Documentation of morbid obesity, as defined by any of the following: <ul style="list-style-type: none"> ○ Body Mass Index (BMI) greater than 40 kg/m² ○ Body weight 45 kilograms (100 pounds) or more above Ideal Body Weight (IBW) ○ Body weight 100 percent or more above IBW
Xolair®	<p>Omalizumab (Xolair®) is considered medically necessary for the treatment of moderate-to-severe persistent asthma in individuals who are at least 12 years-of-age, who had a positive skin test or in vitro reactivity to a perennial aeroallergen, and whose symptoms are inadequately controlled with inhaled corticosteroids</p>
Xyzal®	<p>Levocetirizine (Xyzal®) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> ● Documentation of a diagnosis of allergic rhinitis or urticaria ● Documentation of age greater than or equal to 6 years ● Documentation of a two week trial and failure of, or contraindication to, TWO of the following: <ul style="list-style-type: none"> ○ A cetirizine-containing product ○ A fexofenadine-containing product ○ A loratadine-containing product
Zelapar®	<p>Selegiline hydrochloride (HCl) (Zelapar®) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> ● Documentation of Parkinson's disease ● Documentation of the trial and failure of, intolerance to,

Name of drug/class	Approval Criteria
Zelapar [®] (continued)	or contraindication to other oral non-disintegrating formulations of selegiline HCl
Zmax [®]	<p>zithromycin (ZMAX[®]) is approved when the following inclusion criterion is met:</p> <ul style="list-style-type: none"> • Documentation of contraindication to all other generic formulations of azithromycin
Zolinza [®]	<p>Vorinostat (Zolinza[®]) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documentation of a diagnosis of cutaneous T-cell lymphoma (CTCL) • Documentation of the trial and failure of, or contraindication to, at least two systemic therapies
Zyvox [®]	<p>Linezolid (Zyvox[®]) is approved when at least one of the following inclusion criteria is met:</p> <ul style="list-style-type: none"> • Documentation of a current diagnosis of vancomycin-resistant <i>Enterococcus faecium</i> (VRE) infection, methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) or methicillin-resistant <i>Staphylococcus epidermis</i> (MRSE) infection prescribed by an infectious disease (ID) specialist or prescribed with ID consultation (telephone consultation is acceptable) including name of the ID specialist and date of the consultation within the last 60 days • Documentation of a current bacterial infection with trial and failure of at least one drug from two of the following groups within the last 60 days: <ul style="list-style-type: none"> ○ At least one of the penicillins or cephalosporins ○ At least one of the macrolides or a ketolide ○ At least one of the fluoroquinolones ○ Trimethoprim and sulfamethoxazole ○ At least one of the tetracyclines ○ Clindamycin